DAC (1) $

PTO/SB/65 (10-00)
Approved for use through 12/31/2002. OMB 0651-0016
U.S. Patent and Trademark Office; U.S. DEPARTMENT OF COMMERCE

PETITION TO ACCEPT UNAVOIDABLY DELAYED PAYMENT OF MAINTENANCE FEE IN AN EXPIRED PATENT (37 CFR 1.378(b))

Docket Number (Optional)

Mail to: Assistant Commissioner for Patents
Box DAC
Washington, D.C. 20231

NOTE: If information or assistance is needed in completing this form, please contact Petitions Information at (703) 305-9282.

Patent No. 5,598,947 Application Number 08/377,449

Issue Date Feb 4, 1997 Filing Date _____

CAUTION: Maintenance fee (and surcharge, if any) payment must correctly identify: (1) the patent number (or reissue patent number, if a reissue) and (2) the application number of the actual U.S. application (or reissue application) leading to issuance of that patent to ensure the fee(s) is/are associated with the correct patent. 37 CFR 1.366 (c) and (d).

Also complete the following information, if applicable

The above-identified patent:

☐ is a reissue of original Patent No._____, original issue date _____;
original application number _____,
original filing date _____.

☐ resulted from the entry into the U.S. under 35 U.S.C. 371 of international application _____filed on_____.

02/21/2001 LGIBBS 00000006 5598947

01 FC:283 ~~425.00 OP~~
02 FC:187 700.00 OP

CERTIFICATE OF MAILING (37 CFR 1.8(a))

I hereby certify that this paper (along with any paper referred to as being attached or enclosed) is being deposited with the United States Postal Service on the date shown below with sufficient postage as first class mail in an envelope addressed to the Assistant Commissioner for Patents, Box DAC, Washington, D.C. 20231.

Feb 12, 2001
Date

Signature

Patrick Smith patentee
Typed or printed name of person signing Certificate

Adjustment date: 02/21/2001 LGIBBS
02/20/200 SLUANG1 00000068 5598947
01 FC:699 -1125.00 OP

02/20/2001 SLUANG1 00000068 5598947

01 FC:699 1125.00 OP

PTO/SB/65 (10-00)
Approved for use through 12/31/2002. OMB 0651-0016
U.S. Patent and Trademark Office; U.S. DEPARTMENT OF COMMERCE

1. SMALL ENTITY

☒ XX Patentee claims, or has previously claimed, small entity status. See 37 CFR 1.27.

2. LOSS OF ENTITLEMENT TO SMALL ENTITY STATUS

☐ Patentee is no longer entitled to small entity status. See 37 CFR 1.27(g).

3. MAINTENANCE FEE (37 CFR 1.20(e)-(g))

The appropriate maintenance fee must be submitted with this petition, unless it was paid earlier.

NOT Small Entity Amount Fee (Code)	Small Entity Amount Fee (Code)	
☐ $ _____ 3 1/2 yr fee (183)	☐ $ _____ 3 1/2 yr fee (283)	$425. ?
☐ $ _____ 7 1/2 yr fee (184)	☐ $ _____ 7 1/2 yr fee (284)	$700.
☐ $ _____ 11 1/2 yr fee (185)	☐ $ _____ 11 1/2 yr fee (285)	$1,125

MAINTENANCE FEE BEING SUBMITTED $_____

4. SURCHARGE

The surcharge required by 37 CFR 1.20(i)(1) of $_____ (Fee Code 187) must be paid as a condition of accepting unavoidably delayed payment of the maintenance fee. $700. ??

SURCHARGE BEING SUBMITTED $_____

5. MANNER OF PAYMENT

☐ Enclosed is a check for the sum of $ 1,125.00

☐ Please charge Deposit Account No._____ the sum of $_____. A duplicate copy of this authorization is attached.

☐ Payment by credit card. Form PTO-2038 is attached.

6. AUTHORIZATION TO CHARGE ANY FEE DEFICIENCY

☐ The Commissioner is hereby authorized to charge any maintenance fee, surcharge or petition fee deficiency to Deposit Account No. _____. A duplicate copy of this authorization is attached.

I was told to pay $425. plus $700. for unavoidably delayed payment of maintenance fee.

7. OVERPAYMENT

As to any overpayment made please

OR

☐ Credit to Deposit Account No. _____.

☐ Send refund check.

WARNING: Information on this form may become public. Credit card information should not be included on this form. Provide credit card information and authorization on PTO-2038.

8. SHOWING

The enclosed statement will show that the delay in timely payment of the maintenance fee was unavoidable since reasonable care was taken to ensure that the maintenance fee would be paid timely and that this petition is being filed promptly after the patentee was notified of, or otherwise became aware of, the expiration of the patent. The statement must enumerate the steps taken to ensure timely payment of the maintenance fee, the date and the manner in which the patentee became aware of the expiration of the patent, and the steps taken to file the petition promptly.

9. PETITIONER(S) REQUESTS THAT THE DELAYED PAYMENT OF THE MAINTENANCE FEE BE ACCEPTED AND THE PATENT REINSTATED.

Feb 12, 2001
Date

Signature(s) of Petitioner(s)

(_____)_____
Telephone Number
no phone

Patrick Smith
Typed or printed name(s)

2901 Beverly Blvd.
Address

Los Angeles, CA 90057

ENCLOSURES:

☒ Maintenance Fee payment

☐ Statement why maintenance fee was not paid timely

☒ Surcharge

☐ _____

37 CFR 1.378(d) states: "Any petition under this section must be signed by an attorney or agent registered to practice before the Patent and Trademark Office, or by the patentee, the assignee, or other party in interest."

Feb 12, 2001
Date

Signature

Patrick Smith patentee
Typed or printed name

STATEMENT

(In the space below, please provide the showing of unavoidable delay recited in paragraph 8 above.)

The delay in timely payment of the maintenance fee was unavoidably because I was injured in an accident and lost the vision in my left eye due to a blow to the head. My loss of vision was determined to be due to a vascular problem, hemorrage in the eye, or to a neurological problem, compressed nerve. (see enclosed sample of medical reports)

During the time since the accident and continuing up to now I suffer from Vertigo and fail to properly focus or concentrate due to sense of unbalance continually. I failed due to my injury to act in a timely manner, finally realizing the need to do so today. I called the Patent Office and was told what to do.

Sincerely,

Patrick Smith

(Please attach additional sheets if additional space is necessary)

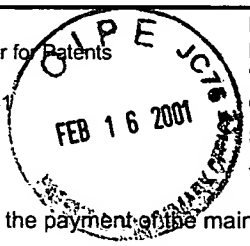
PTO/SB/45 (01-01)
Approved for use through 12/31/2002. OMB 0651-0016
U.S. Patent and Trademark Office; U.S. DEPARTMENT OF COMMERCE

Please type a plus sign (+) inside this box ☐

Under the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

MAINTENANCE FEE TRANSMITTAL FORM

Address to:
Assistant Commissioner for Patents
Box M Fee
Washington, D.C. 20231



I hereby certify that this correspondence is being deposited with the United States Postal Service with sufficient postage as first class mail in an envelope addressed to "Assistant Commissioner for Patents, Box M Fee, Washington D.C. 20231" on Feburary 12, 2001.

Signature_____.

Typed or printed name Patrick Smith patentee.

Enclosed herewith is the payment of the maintenance fee(s) for the listed patent(s).

1. ☒ A check for the amount of $1,125.00 for the full payment of the maintenance fee(s) and any necessary surcharge on the following patents is enclosed.
2. ☐ The Commissioner is hereby authorized to charge $_____ to cover the payment of the fee(s) indicated below to Deposit Account No._____.
3. ☐ The Commissioner is hereby authorized to charge any deficiency in the payment of the required fee(s) or credit any overpayment to Deposit Account No._____.
4. ☐ Payment by credit card. Form PTO-2038 is attached.

*Information required by 37 CFR 1.366(c) (columns 1 & 4). Information requested under 37 CFR 1.366(d) (columns 2, 3, 5, & 6)

Item	Patent Number*	Maintenance Fee Amount (37 CFR 1.20 (e)-(g))	Surcharge Amount (37 CFR 1.20 (h)-(i))	U.S. Application Number* [06/555,555]	Payment Year 5			Small Entity? **
					3.5 yrs	7.5 yrs	11.5 yrs	
	1	2	3	4				6
1	5,598,947	$425.00	$700.00		X			X
2								
3								
4								
5								
6								
Subtotals__Columns 2 & 3								
Total Payment								

☐ _____additional sheets attached for listing additional patents.

WARNING: Information on this form may become public. Credit card information should not be included on this form. Provide credit card information and authorization on PTO-2038.

Respectfully submitted***:

Customer's name: Patrick Smith

Telephone: no phone

Fax:

Customer's Signature: Patrick Smith

Note. *All correspondence will be forwarded to the "Fee Address" or to the "Correspondence Address" if no "Fee Address" has been provided. 37 CFR 1.363.

**Payment of small entity fee is appropriate if small entity status still exists, see 37 CFR 1.27(g). To establish small entity status or to change status from small to large entity, note the requirements of 37 CFR 1.27 and 1.33(b).

***WHERE MAINTENANCE FEE PAYMENTS ARE TO BE MADE BY AUTHORIZATION TO CHARGE A DEPOSIT ACCOUNT, BOTH CUSTOMER'S NAME AND SIGNATURE ARE REQUIRED.

Burden Hour Statement: This collection of information is required by 37 CFR 1.366. This information is used by the public to submit (and by the USPTO to process) payment of patent maintenance fees. Confidentiality is governed by 35 U.S.C. 122 and 37 CFR 1.14. This collection is estimated to take 0.08 hours to complete, including gathering, preparing, and submitting the complete payment of maintenance fees. Time will vary depending on the individual case. Any comments on the amount of time you require to complete this form and/or suggestions for reducing this burden should be sent to the Chief Information Officer, U.S. Patent and Trademark Office, U.S. Department of Commerce, Washington, DC 20231. DO NOT SEND FEES OR COMPLETED FORMS TO THIS ADDRESS. SEND TO: Assistant Commissioner for Patents, Washington, DC 20231.

PATIENT INFORMATION SHEET

PLEASE COMPLETE FORM IN PRINT

ARRIVAL TIME: 11:35

PLEASE NOTE: PATIENTS ARE SEEN ACCORDING TO THE SEVERITY OF THEIR COMPLAINT AND NOT NECESSARILY IN THE ORDER IN WHICH THEY SIGNED IN. THIS DECISION WILL BE MADE BY THE NURSE. THANK YOU FOR YOUR UNDERSTANDING.

LAST	FIRST	MI
SMITH	PATRICK	

PATIENT NAME

BIRTHDATE	AGE	SEX
June 20, 1934	65	Male

487 34 0635
SOCIAL SECURITY NUMBER

Hit in head in auto accident
REASON YOU ARE HERE TODAY

PRIVATE DOCTOR	MD PHONE #
None	

No Private Doctor ☒ Clinic Patient ☐

ARE YOU TAKING ANY MEDICATIONS? YES ☐ NO ☒
If yes, please list (prescription and non-prescription)

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ☐ NO ☒
If yes, please list

Aspirin ☐ Penicillin ☐ Sulfa ☐

Other:

5/9/00

Discharge Instructions from S. LEVINE, MD
Saint John's Hospital and Health Center Emergency Department

DIZZINESS:
Dizziness is a common problem that has many causes. Most illnesses and many medications can cause dizziness along with other symptoms. It may at times signal a problem with the heart or circulation. Even many minor diseases, such as viral infections, often have dizziness as one of the main symptoms.

Vertigo is a kind of dizziness that gives the sensation that you or your surroundings are spinning. This usually involves the balance centers in the inner ear - and is often caused by a virus infection. In the elderly, poor circulation to the brain will often cause vertigo.

The actual cause of an episode of dizziness is often very hard to pinpoint. Your evaluation today indicates that a serious cause is not likely. You should remain at rest until you are feeling better. If your symptoms persist or worsen, or if other symptoms develop, you will need follow-up with your doctor or the Emergency Department.

NOTIFY YOUR DOCTOR or return here in case of the following:
- Dizziness is worsening or any fainting.
- Chest pain or discomfort of any kind, or irregular heartbeat.
- Abdominal or back pain that is worsening or changing in location.
- Prolonged or high fever.
- Severe or worsening headache.
- Change in mental status - too sleepy, confused, short of breath, irritable, slurred speech, weakness, or difficulty walking.
- Repeated vomiting or inability to retain fluids.

OTHER INSTRUCTIONS:
YOU WERE EVALUATED IN THE EMERGENCY ROOM FOR DIZZINESS BY DR. S. LEVINE, THE CARDIOLOGIST. FOLLOW UP WITH HIM AT HIS OFFICE TOMORROW AS DIRECTED. RETURN SOONER TO THE ER FOR ANY CHANGE IN OR WORSENING OF SYMPTOMS

If you have more questions or problems with your medical condition or the treatment, see your doctor or call us at number (310) 829-8212.

My signature indicates that I understand, and have received a copy of, the above instructions.

_____

5/9/00

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Saint John's Hospital and Health Center Emergency Department

DIZZINESS:
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If you have more questions or problems with your medical condition or the treatment, see your doctor or call us at number (310) 829-8212.

My signature indicates that I understand, and have received a copy of, the above instructions.

_____

Best Available Copy

DMV Public Service Agency

REPORT OF VISION EXAMINATION

(Form valid for 6 months from examination date)

APPLICANT COMPLETES THIS SECTION

DRIVER LICENSE NUMBER	DATE OF BIRTH (MO., DAY, YR.)	HOME TELEPHONE NUMBER
P0440873	6-20-34	

NAME (FIRST, MIDDLE, LAST): Patrick Smith

RESIDENCE ADDRESS: 2901 Beverly Blvd. CITY: Los Angeles STATE: Ca. ZIP CODE: 90057

APPLICATION DATE: 2.3.00 FIELD OFFICE: Santa Monica

I authorize the vision specialist conducting this examination to provide the Department of Motor Vehicles (DMV) with the following information for its confidential use (CVC1808.5) in evaluating my ability to safely operate a motor vehicle.

APPLICANT'S SIGNATURE: DATE:

OPHTHALMOLOGIST OR OPTOMETRIST COMPLETES THIS SECTION

REFRACTION

HAVE NEW DISTANCE LENSES BEEN PRESCRIBED AND FITTED?
☐ Yes ☐ No If yes: ☐ Glasses ☐ Contact Lenses ☐ Bioptic Telescope

DATE NEW LENSES WERE PRESCRIBED: 2-9-2000

IF DISTANCE LENSES WERE PRESCRIBED AND FITTED, IS THIS THE BEST POSSIBLE CORRECTION? IF NO, EXPLAIN.
☑ Yes ☐ No History of Recent Trauma L.E. Requiring Evaluation

IF A BIOPTIC TELESCOPIC LENS WAS PRESCRIBED, IS IT
☐ Galilean ☐ Keplerian ☐ Periscope/Keplerian ☐ Other

DID YOUR PATIENT RECEIVE TRAINING IN USING THE BIOPTIC TELESCOPIC LENS?
☐ Yes ☐ No

IF YES, WAS DRIVING INCLUDED IN THE TRAINING?
☐ Yes ☐ No

VISUAL ACUITY

DMV MEASUREMENT (ORTHORATER OR EQUIVALENT)

	Both Eyes	Right Eye	Left Eye
Without Lenses	T/ 20/40	T/ 20/40	T/ Ø
With Lenses	T/	T/	T/

CLINICAL MEASUREMENT

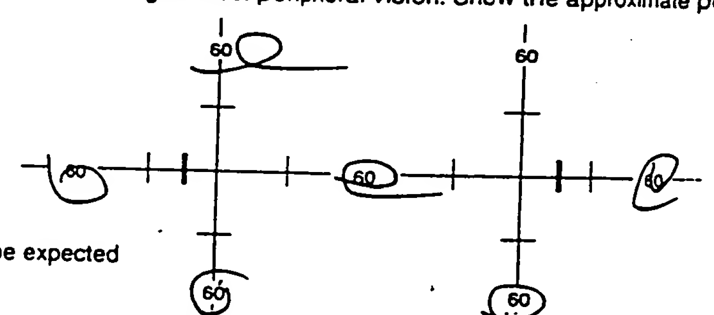
	Both Eyes	Right Eye	Left Eye
Without Lenses	20/ 50	20/ 50	20/ 400
With Correction	20/ 25	20/ 25	20/ 100

VISUAL FIELDS

A full visual field examination extending at least 60°, using a standard test object such as a 10mm white mark, must be performed if any condition exists which might affect peripheral vision. Show the approximate peripheral extent and any scotomas in the diagram below.

LEFT EYE

Extent:
Left 180
Right 90
Up 180
Down 90



RIGHT EYE

Extent:
Left 180
Right 90
Up 180
Down 90

☐ No condition exists that would be expected to impair visual fields.
☐ Diagram is attached.

DIAGNOSIS

Please indicate the severity of the vision condition by placing a number 1, 2, or 3 in the box representing the affected eye(s) (1 = mild 2 = moderate 3 = severe). Definitions of mild, moderate, and severe, for each condition can be obtained from DMV. If your patient has Hemianopia or Pseudophakia, check the box representing the affected eye.

Condition	R	L
Amblyopia	☐	☐
Hyperopia	☐	☐
Scotoma	☐	☐
Retinitis Pigmentosa	☐	☐
Monocular	☐	☐
Aphakia	☐	☐
Hemianopia*	☐	☐
Decreased Peripheral Vision	1	2
Astigmatism	1	3
Keratoconus	☐	☐
Diabetic Retinopathy	☐	☐
Cataract	☐	☐
Myopia	☐	☐
Macular Degeneration	☐	☐
Diplopia	☐	☐
Nystagmus	☐	☐
Retinal Detachment	☐	☐
Glaucoma	☐	☐
Pseudophakia	☐	☐
Strabismus	☐	☐
Other	1	3

Could the condition in the blind eye affect the fellow eye in the future? ☐ Yes ☐ No
When was the monocular vision diagnosed?

Other: Requires Full Work-up Not Including Scan of L.E

*Hemianopia: Please identify the quadrants affected on the chart above.

PROGNOSIS

☐ Stable ☐ Potentially progressive ☑ Improvement possible

PLEASE ESTIMATE HOW SOON YOUR PATIENT'S VISION SHOULD BE REEVALUATED. 6 mos Reports Trauma Med. Eval. L.E
☑ 6 mos. ☐ 1 year ☐ 2 years ☐ 4 years ☐ Other

ADVICE

WHAT ADVICE HAVE YOU GIVEN YOUR PATIENT ABOUT DRIVING?
☐ Drive in familiar areas only ☐ No night driving ☐ Do not drive ☐ No advice given ☐ Other

PRINTED NAME: Laurice Friedman OD
SIGNATURE: X [signature]
M.D. OR O.D. LICENSE NUMBER: 4423
DATE OF EXAM: 2-2-2000
ADDRESS: 10724 Washington Blvd CITY: Culver City Ca ZIP CODE:
TELEPHONE NUMBER: (310) 559 0500

Eyes Examined • Contacts • Glasses
Emergency Service

10724 Washington Blvd.
Culver City, CA 90230

(213) 870-2848
(310) 559-0500
FAX (310) 559-4009

3/17/00

re: Smith, Patricia
8/20/34

Visual Acuity OS (left eye) today is 20/200+1 best corrected. Pin hole visual acuity gives minimal improvement to 2/100-4/4 Based on patient provided form, this is a 25% Reduction

2.- VISION

2.1- LOSS OF SIGHT WITH COSMETIC EFFECT

Enucleation (or evisceration) of one eye:

2.121	With ability to wear artificial eye	30%
2.131	With inability to wear artificial eye.....	35%

Loss of sight of one eye[5]

2.141	With marked blemish that would afford an observer evidence of the loss.....	30%

2.2- LOSS OF SIGHT

2.211	Loss of sight of one eye with no blemish that would afford an observer evidence of the loss	25%
2.213	Loss of both eyes or the sight thereof	100%

4 Consideration may be given to such factors as: ptosis of eyelid, entropion (turning in of the lid), ectropion (turning out of the lid), lacrimation, photophobia, chronic conjunctivitis, enlarged pupil, coloboma (irregular pupil), blurring, scarring of the eyeball.

5 In case of loss of sight with blemish, the standard will vary between the ratings for disabilities 2.141 and 2.211, depending on the degree of the disfigurement.

2.3 REDUCTION OF VISION[6]

2.311 Reduction of vision, one eye to:[7]

Distance (Snellen) as index	Near (Jaeger) as index	
20/20	1,2,3,4	0%
20/30	5	3%
20/40		5%
20/50		7%
20/60		9%
20/70		11%
20/80		13%
20/100	6	16%
20/125	7,8	19%
20/150		22%
20/200	9	25%

2.313 Reduction of vision of both eyes[8]

2.4 APHAKIA (LOSS OF NATURAL LENS)[9]

One eye, correction of visual acuity with spectacle lens to:

2.411	20/25 or better.....	20%
2.421	20/30 to better than 20/50.....	21%

6 Ratings are based on vision with best practicable correction.

7 When reduction of distance and near vision are both present, use index which produces the higher standard rating.

8 To obtain rating for bilateral reduction of vision, see Table 1C "Eyes - Bilateral Reduction of Vision", on page 7-3.

9 In cases of aphakia with practicable correction by means other than spectacle lens, the standard rating shall be based on disability found under reduction of vision (disability 2.3) plus 1/2 the difference between disabilities 2.4 and 2.3.

) 859-0290

ALI A. KASHANI, M.D.
DEIPLOMATE. AMERICAN BOARD OF OPHTHALMOLOGY
436 NOTRH ROXBURY DRIVE SUITE 114
BEVERLY HILLS, CALIFORNIA 90210
U.S.A

ember 14, 1999

Mr. Smith Patrick

Whom It May Concern:

se be advised that Mr. Patrick Smith was seen at our office for his eye condition and he paid
).00 for today's visit. He needs to have three more follow up visits with me, and a visual
i test. Mr. Smith needs to pay $600 for the follow up visits and required tests. Mr. Smith has
seen at Cedars-Sinai Hospital before, and he was reportedly diagnosed with left anterior
nber hemorrhage. His eye pressure is normal right now but he needs follow up. He may also
ire B-scan.

nk you for your attention. Please do not hesitate to call us if you have any questions.

erely Yours,
A. Kashani, M.D.

U C L A H E A L T H C A R E
UCLA MEDICAL CENTER
PATIENT STATEMENT OF ACCOUNT - DETAIL

PATIENT NAME: SMITH, PATRICK

ACCOUNT NBR: 000073088-3022
BILLING PERIOD: 07/29/00 09/01/00

BILL TO
PATRICK SMITH
2901 BEVERLY BLVD
LOS ANGELES CA 90057

SRV DATE	REF NBR	DESCRIPTION	
07/27/00	15400023	CHLORIDE, SERUM	33.0(
07/27/00	15400029	CO2 CONTENT, SERUM	33.0(
07/27/00	15400031	CREATININE	33.0(
07/27/00	15400042	GLUCOSE	33.0(
07/27/00	15400072	POTASSIUM	33.0(
07/27/00	15400079	SODIUM	33.0(
07/27/00	15400086	UREA NITROGEN	59.0(
07/27/00	15400266	CBC & PLT & DIFF	36.0(
07/27/00	15400380	PT	49.2(
07/27/00	15400353	APTT	243.00
07/27/00	28900027	ER LEVEL IV	8.00
07/27/00	28900631	ELECTRODES	142.00
07/27/00	28900193	INTRAVENOUS STARTS	

-- WE HAVE BILLED THE FOLLOWING INSURANCE(S) --
MEDI-CAL 07/29/00 - 08/31/00

REMIT TO
UCLA HEALTHCARE
10920 WILSHIRE BLVD
SUITE 1600
LOS ANGELES CA 90024

BEGINNING BALANCE	0.00
NEW CHARGES/ADJUSTMENTS	768.20
NEW PAYMENTS/CREDITS	0.00
CURRENT ACCOUNT BALANCE	768.20

MAKE CHECK PAYABLE TO: UCLA HEALTHCARE

IF YOU HAVE ANY QUESTIONS CONCERNING THIS STATEMENT PLEASE CONTACT:
CUSTOMER SERVICE PHONE: (310) 825-8021

U C L A H E A L T H C A R E
UCLA MEDICAL CENTER
PATIENT STATEMENT OF ACCOUNT - DETAIL

PAGE
09/01/00 15:3

PATIENT NAME: SMITH, PATRICK

ACCOUNT NBR: 000073088-3022
BILLING PERIOD: 07/29/00 09/01/00

BILL TO
PATRICK SMITH
2901 BEVERLY BLVD
LOS ANGELES CA 90057

SRV DATE	REF NBR	DESCRIPTION	
07/27/00	15400023	CHLORIDE, SERUM	33.0(
07/27/00	15400029	CO2 CONTENT, SERUM	33.0(
07/27/00	15400031	CREATININE	33.0(
07/27/00	15400042	GLUCOSE	33.0(
07/27/00	15400072	POTASSIUM	33.0(
07/27/00	15400079	SODIUM	33.0(
07/27/00	15400086	UREA NITROGEN	33.0(
07/27/00	15400266	CBC & PLT & DIFF	33.0(
07/27/00	15400380	PT	59.0(
07/27/00	15400353	APTT	36.0(
07/27/00	28900027	ER LEVEL IV	49.2(
07/27/00	28900631	ELECTRODES	243.00
07/27/00	28900193	INTRAVENOUS STARTS	8.00
			142.00

-- WE HAVE BILLED THE FOLLOWING INSURANCE(S) --
MEDI-CAL 07/29/00 - 08/31/00

REMIT TO
UCLA HEALTHCARE
10920 WILSHIRE BLVD
SUITE 1600
LOS ANGELES CA 90024

BEGINNING BALANCE	0.00
NEW CHARGES/ADJUSTMENTS	768.20
NEW PAYMENTS/CREDITS	0.00
CURRENT ACCOUNT BALANCE	768.20

MAKE CHECK PAYABLE TO: UCLA HEALTHCARE

IF YOU HAVE ANY QUESTIONS CONCERNING THIS STATEMENT PLEASE CONTACT:
CUSTOMER SERVICE PHONE: (310) 825-8021

All labs, EKGs, plain x-rays, oxygen saturations and rhythm strips are interpreted by the ED physician unless otherwise specified

Pulse Ox: SO2 _____ % _____ %
Rhythm strip: Rate 77 (NSR) Afib Aflutter SVT
Occasional / frequent PACs / PVCs
Sinus bradycardia / tachycardia Other _____
EKG: Rate 75 (NSR) Axis wnl Intervals wnl
Sinus bradycardia / tachycardia Afib Aflutter SVT
Vtach LSBB RBBB LAFB Q's _____ LVH
NSSTTJ's PRWP Occasional / frequent PACs / PVCs
ST elevation _____ mm Leads _____
ST depression _____ mm Leads _____
Dx: ☒Normal EKG ☐Borderline EKG ☐Abnormal EKG
CXR: nl heart size CM CHF Infiltrate _____
NO INFILTRATES
Dx: ☒Normal CXR ☐Borderline CXR ☐Abnormal CXR

Laboratory and radiographic results:
CK-81
TROP <0.15
8.1 / 14.4 / 267,000 / 43
140 | 103 | 18 / 115
3.9 | 26 | 0.9
Ca-8.9

ED course: ☐Reassessments ☐Consultations ☐Procedure note ☐Prior records reviewed

☐Admitted to ED observation [DATE/TIME] EDMD _____ Observation note (*Re-exam required*) Dx: _____

Procedures: Central line Chest tube CPR ET intubation FB removal Nerve block I&D LP Slit lamp exam Restraints Other _____
☐Laceration repair: Length _____ cm
Simple / Complex Anesthesia _____
☐Irrigated w/NS Suture _____
Type _____ Number _____
☐Fracture(Fx)/Dislocation(D) care:
Bone Fx'd / D _____
Fx: Displaced / Nondisplaced
☐Initial treatment and stabilization
☐Treatment: Application of Sling / Splint
☐Conscious Sedation: Reason: _____
Sedation/Analgesic agent(s) _____
Post-procedure evaluation: [TIME]
☐Awake, alert, ambulatory ☐Vital signs stable
☐Conscious sedation protocol followed-see nursing record

Clinical Impression: 1] ACUTE DIZZINESS
2] GASTROESOPHAGEAL REFLUX DISEASE
3] _____
4] _____
5] _____

Disposition: ☒Home ☐Left AMA Admitted by Dr. _____ To _____
Transferred to _____ By _____ No. _____ Accepted by Dr. _____
☐Stable for transfer ☐Unstable for transfer ☐Transferred to a higher level of care
Condition on disposition or transfer: ☒Stable ☐Unstable ☐Expired
CRITICAL CARE TIME _____ minutes

ED PA/MD Discussed with Dr. _____ Signed out to Dr. _____
History and physical exam performed and clinical decisions made by Dr. _____
1] Alan Heilper MD 3]

ACI: Abdominal pain Ankle sprain Asthma
Back pain Chest pain Diarrhea Fever Headache
Head injury UTI Viral syndrome Vomiting Wound
Wound ✓ _____ days Suture removal _____ days
Follow up in _____ with _____
Do not drive while taking _____
☑ RTED or PMD for a worsening of symptoms
☑ Instructions explained & questions answered
☐Left AMA ☐Risks explained ☐Pt competent
F/U AT UCLA-NEURO TOMORROW AS SCHEDULED

ADDRESSOGRAPH

Saint John's Health Center
Santa Monica, CA 90404

SMITH, PATRICK
M0003154 L015772940 06/
HEILPERN, ALAN H.

EMERGENCY DEPARTMENT SUMMARY

09/06/00 M 56 REG ER

WHITE - CHART YELLOW - BILLING PINK - DEPARTMENT

Best Available Copy

VN# 3023

034/195-39-54 3
SMITH, PATRICK
M 66 06/20/1934 SML
08/30/00 ODOPC

195-39-54 3023 2

(Medical)

UCLA HOSPITAL & CLINICS
CONSULTATION REQUEST

PATIENT'S FLOOR	PATIENT'S ROOM	SERVICE

REQUESTING PHYSICIAN: Lynn Gordon

REQUESTING PHYSICIAN'S TELEPHONE NUMBER: page 09701

NAME OF CONSULTING PHYSICIAN REQUESTED: ANY Neurology clinic

PHYSICIAN REQUIRED IS: ☐ ATTENDING PRIVATE ☐ PERSONAL PRIVATE

DATE OF CONSULTATION REQUEST: 8/30/00

CONSULTATION RE[...] BY THIS DATE: ASAP

MEDICINE	PEDIATRICS	SURGERY	OTHER SPECIALTIES
☐ GENERAL MEDICINE	☐ GENERAL PEDS	☐ GENERAL SURGERY	☐ ANESTHESIA
☐ CARDIOLOGY	☐ PEDS CARDIOLOGY	☐ GEN., VASCULAR & PED. SURGERY	☐ AUDIOLOGY & SPEECH
☐ CLIN. IMMUNOLOGY-ALLERGY	☐ PEDS ENDOCRINOLOGY	☐ GEN. & ABDOMINAL SURGERY	☐ DENTISTRY-INPATIENT
☐ CLIN. PHARMACOLOGY	☐ PEDS GASTROENTEROLOGY	☐ ONCOLOGICAL SURGERY	☐ DENTISTRY-OUTPATIEN[...]
☐ DERMATOLOGY	☐ PEDS GENETICS	☐ HEAD & NECK (OTOLARYNGOLOGY)	☑ NEUROLOGY
☐ ENDOCRINOLOGY-METABOLISM	☐ PEDS HEMATOLOGY	☐ NEUROSURGERY	☐ OB/GYN
☐ GASTROENTEROLOGY	☐ PEDS IMMUNOLOGY	☐ ORAL & MAXILLOFACIAL SURGERY	OCCUPATIONAL THERA[...] (use their request form no.[...]
☐ GENETICS	☐ PEDS INFECTIOUS DISEASE	☐ ORTHOPEDICS	☐ OPHTHALMOLOGY
☐ HEMATOLOGY-ONCOLOGY	☐ PEDS NEPHROLOGY	☐ PLASTIC SURGERY	☐ PATHOLOGY
☐ INFECTIOUS DISEASE	☐ PEDS NEUROLOGY	☐ THORACIC SURGERY	PHYSICAL THERAPY (use their request form no.[...]
☐ NEPHROLOGY-HYPERTENSION	☐ CHILD DEVELOPMENT	☐ UROLOGY	☐ PSYCHIATRY (CALL 50[...]
☐ PULMONARY	☐ ______	☐ ______	☐ PROSTHETICS
☐ REHABILITATION MEDICINE			☐ RADIOLOGY-DIAGNOST[...]
☐ RHEUMATOLOGY-ARTHRITIS			☐ RADIOLOGY-NUCLEAR[...]
☐ ______			☐ RADIOLOGY-THER (CAL[...]
			☐ SOCIAL SERVICE

THIS CONSULTATION IS ☐ ROUTINE ☐ URGENT

STATE THE PROBLEM: 66 yo ♂ s/p Left supraorbital trauma.
w/ accident c/o dizzy, i episode LOC → UCLA ER
pt signed out AMA. Pt requested to have MRI [...]
not done, continues to have dizziness.

in cedars since
ER and has
put off that [...]

Appt:
10/24/00, Tues 3
DR DOMINICK

SEND REQUEST TO HOUSE STAFF [...] ROOM [...]

[...] TELEPHONE APPROPRIATE NUMBE[...]

VN# 3023

034/195-39-54 3
SMITH, PATRICK
M 66 06/20/1934 SML
08/30/00 ODOPC

195-39-54 3023 2

(Medical)

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☐ CARDIOLOGY	☐ PEDS CARDIOLOGY	☐ GEN., VASCULAR & PED. SURGERY	☐ AUDIOLOGY & SPEECH
☐ CLIN. IMMUNOLOGY-ALLERGY	☐ PEDS ENDOCRINOLOGY	☐ GEN. & ABDOMINAL SURGERY	☐ DENTISTRY-INPATIENT
☐ CLIN. PHARMACOLOGY	☐ PEDS GASTROENTEROLOGY	☐ ONCOLOGICAL SURGERY	☐ DENTISTRY-OUTPATIEN[T]
☐ DERMATOLOGY	☐ PEDS GENETICS	☐ HEAD & NECK (OTOLARYNGOLOGY)	☑ NEUROLOGY
☐ ENDOCRINOLOGY-METABOLISM	☐ PEDS HEMATOLOGY	☐ NEUROSURGERY	☐ OB/GYN
☐ GASTROENTEROLOGY	☐ PEDS IMMUNOLOGY	☐ ORAL & MAXILLOFACIAL SURGERY	OCCUPATIONAL THERA[PY] (use their request form no.
☐ GENETICS	☐ PEDS INFECTIOUS DISEASE	☐ ORTHOPEDICS	☐ OPHTHALMOLOGY
☐ HEMATOLOGY-ONCOLOGY	☐ PEDS NEPHROLOGY	☐ PLASTIC SURGERY	☐ PATHOLOGY
☐ INFECTIOUS DISEASE	☐ PEDS NEUROLOGY	☐ THORACIC SURGERY	PHYSICAL THERAPY (use their request form no.
☐ NEPHROLOGY-HYPERTENSION	☐ CHILD DEVELOPMENT	☐ UROLOGY	☐ PSYCHIATRY (CALL 502
☐ PULMONARY	☐ ______	☐ ______	☐ PROSTHETICS
☐ REHABILITATION MEDICINE			☐ RADIOLOGY-DIAGNOST[IC]
☐ RHEUMATOLOGY-ARTHRITIS			☐ RADIOLOGY-NUCLEAR
☐ ______			☐ RADIOLOGY-THER (CAL[L]
			☐ SOCIAL SERVICE

THIS CONSULTATION IS ☐ ROUTINE ☐ URGENT

STATE THE PROBLEM: 66 yo ♂ s/p Left supraorbital trauma w/ accident c/o dizzy, ī episode LOC → UCLA ER pt signed out AMA. Pt requested to have MRI [...] not done, continues to have dizziness.

in cedars since ER and being put ophthalmolo[gy]

Appt: 10/24/00, Tues 3
DR DOMINICK

SEND REQUEST TO HOUSESTAFF [...] APPROPRIATE NUMBE[R]

Best Available Copy

195-39-54 3 VN# 3023
H, PATRICK
66 06/20/1934 SML
08/30/00 ODOPC
195-39-54 3023 2

UNIVERSITY OPHTHALMO ASSOCIATES

JULES STEIN EYE INSTITU
100 Stein Plaza, UCLA
First Floor
Box 957000
Los Angeles, CA 90095-7000
(310) 825-3090

Follow-up Examination

OT

Patient Name:

Date: 8-30-00

Age and Sex: 66 yo m

Date of Prior Examination: 9-17-9

INTERVAL HISTORY:

S/P KPE/PCIOL, OD

Pt was involved in a car accident last 12/1/99 & loss vision in OS. car door struck by 2nd vehicle and door slammed back across (L) orbit – bruising above ... orbital ridge. Lost Va OS immediately. → dizzy → cedars since → told of hyphema OS → Dr. ... next day ... MRI performed on ... → Not performed 2° financial constraints Insurance Co would not pay. told of probable compressed nerve. did not return for treatment – recommend Rx. – vision never recovered. 1 month ago → LOC in pharmacy taken to ER at left ER AMA. f/u Cedars-ER No MRI or CT since accident

Contact Lens Hx:

Average Wearing Time:

Wearing Time Today:

Contact Lens Solutions:

Medications: Ø gtts. NKDA alancolne – sto...

VISUAL ACUITY:

(sc) RE 20/60 PH ____ sc Near ____
cc LE CF 6" PH ____ cc Near ____

WEARING PRESCRIPTION:

RE ____
LE ____
Add ____

REFRACTION:

Manifest: Dist: Add: Near:

RE -1.00 VA 20/20-2 +2.50 VA 20/20
LE Balance VA ____ ____ VA ____

Over-Refraction: +0.50 pl 20/20

RE ____ VA ____ 7+7-... CAPD OS.
LE ____ VA ____

Cycloplegic:

RE ____ VA ____
LE ____ VA ____

KERATOMETRY:

RE ____
LE ____

SLIT LAMP EXAMINATION	RE	LE	
Eyelids/lashes			☑ normal OU
Conjunctive			☑ clear OU
Cornea			☑ clear OU
Anterior Chamber			☑ deep & quiet OU
Iris			☐ normal OU
Lens	PCIOL	2+ NS 1+ cortical PSC OS	☐ clear OU

INTRAOCULAR PRESSURE: ✓ Applanation ____ Pneumotonometer ____ Tono

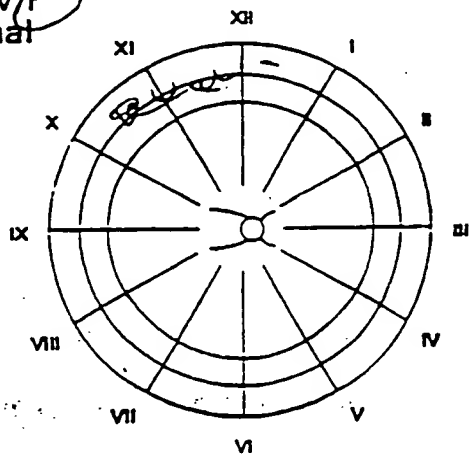
RE 12 mm Hg LE 14 mm Hg Time 9:55 A

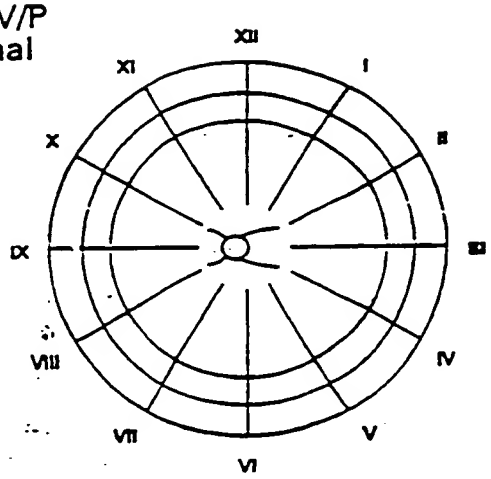
Best Available Copy

DILATED EXAMINATION: (Agent: M1 $M1/2$ C1 $C1/2$ CM N2.5 N10 A1)

Time: 10:35

Optic Nerve Heads	RE	LE
	◯	◯ cup/disc <
☑ D/M/V/P normal	mild Δ's	
☑ D/M/V/P normal		





IMPRESSION:

ATTENDING:

A/ s/p trauma - request VF
① ? poss to RAPD but doubt
② cataract ↓ VF OK
consider CE
③ dizzy - refer to neurology.

RECOMMENDATIONS:

PHYSICIANS CONTACTED: ☐ Letter ☐ Telephone

Follow-up:

Signature: _____

Supervising Faculty: _____

Best Available Copy

Single Field Analysis — Eye: Right

Name: SMITH,PATRICK — ID: 1953954 — DOB: 06-20-1934

Central 30-2 Threshold Test

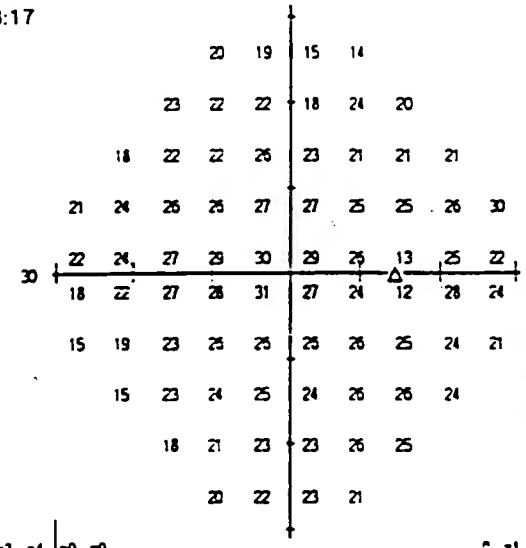
Fixation Monitor: Blindspot
Fixation Target: Central
Fixation Losses: 8/19
False POS Errors: 1 %
False NEG Errors: 0 %
Test Duration: 08:17

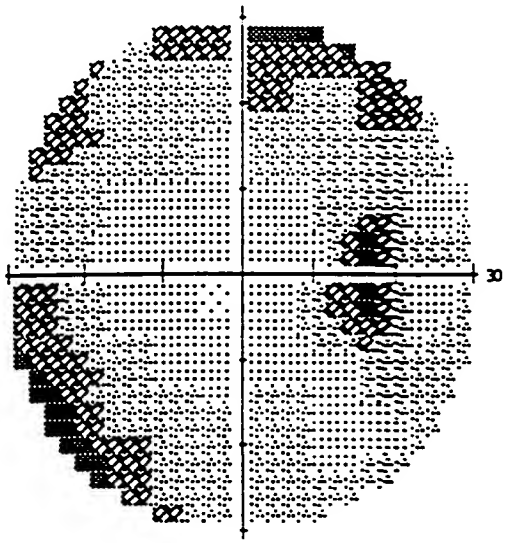
Stimulus: III, White
Background: 31.5 ASB
Strategy: SITA-Standard

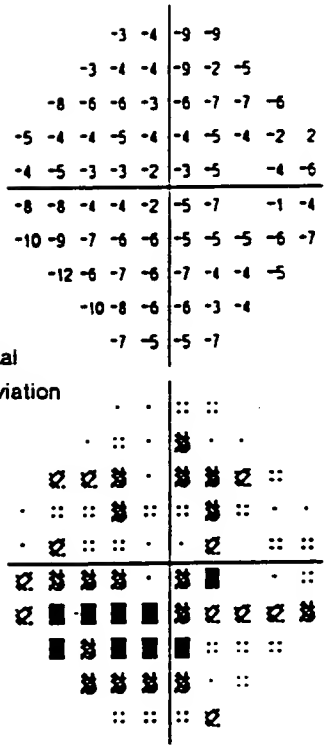
Pupil Diameter:
Visual Acuity:
RX: +2.25 DS DC X

Date: 09-01-2000
Time: 2:39 PM
Age: 66

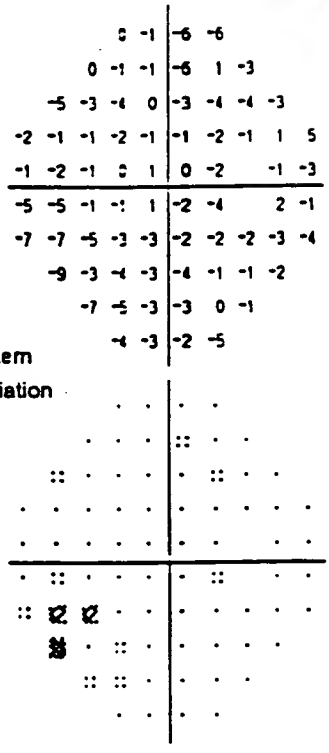
Fovea: 33 dB







Total Deviation



Pattern Deviation

:: < 5%
⊠ < 2%
▒ < 1%
■ < 0.5%

GHT
General Reduction of Sensitivity

MD -5.04 dB P < 0.5%
PSD 2.42 dB P < 10%

JULES STEIN EYE INSTITUTE / U.C.L.A.
GLAUCOMA DIVISION, 2ND FLOOR
VISUAL FIELD LAB, ROOM 2
100 STEIN PLAZA, L.A.,CA 90095
310-794-9442 FAX 310-794-5541.

HFA II 750-3877-Rev. A10.2

Field Analysis — Eye: Left

e: SMITH,PATRICK — ID: 1953954 — DOB: 06-20-1934

tral 30-2 Threshold Test

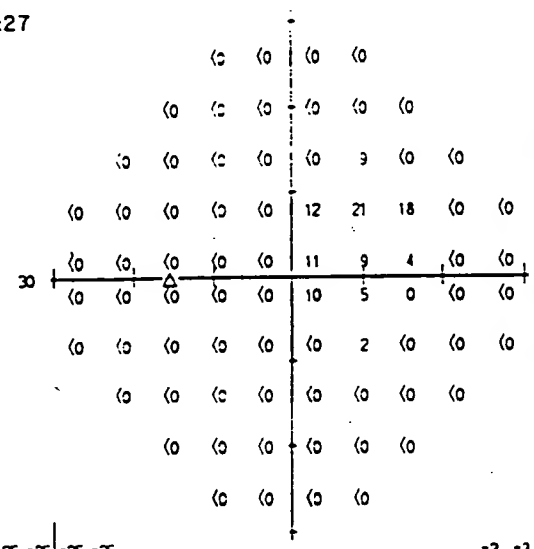
Fixation Monitor: Blindspot
Fixation Target: Central
Fixation Losses: 0/15
False POS Errors: 0 %
False NEG Errors: 99 %
Test Duration: 06:27

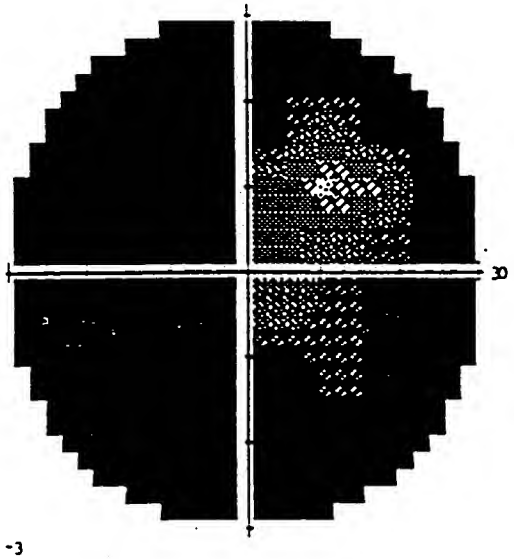
Stimulus: III, White
Background: 31.5 ASB
Strategy: SITA-Standard

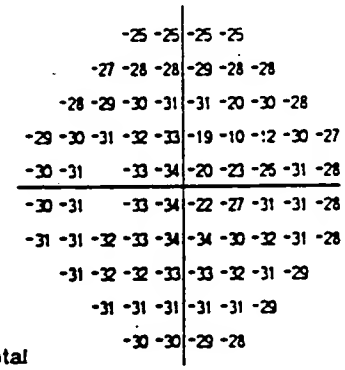
Pupil Diameter:
Visual Acuity:
RX: +3.75 DS DC X

Date: 09-01-2000
Time: 2:51 PM
Age: 66

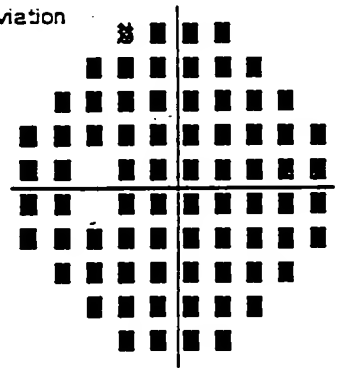
Fovea: 19 dB

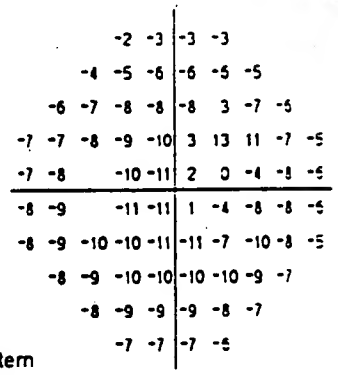




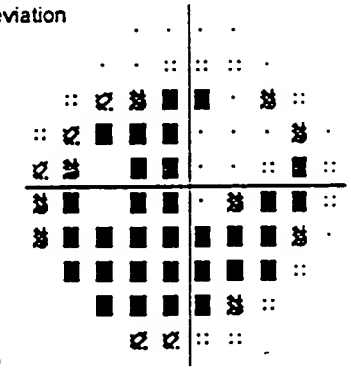


Total Deviation





Pattern Deviation



:: < 5%
⊠ < 2%
▩ < 1%
■ < 0.5%

GHT
Outside normal limits

MD -29.00 dB P < 0.5%
PSD 6.05 dB P < 0.5%

JULES STEIN EYE INSTITUTE / U.C.L.A.
GLAUCOMA DIVISION, 2ND FLOOR
VISUAL FIELD LAB, ROOM 2
100 STEIN PLAZA, L.A.,CA 90095
310-794-9442 FAX 310-794-5541

HFA II 750-3877-Rev. A10.2

Best Available Copy

036/195-39-54 3 07/27/00
SMITH, PATRICK
M 66 06/20/1934 SML

VN# 3022

UCLA MEDICAL CENTER

LEAVING HOSPITAL AGAINST MEDICAL ADVICE

INSTRUCTIONS: Complete all blanks. Strike words that do not apply. The physician completes the "Advice" section. The patient signs the "Release" section.

Patrick Smith
PATIENT'S NAME

PERSON BEING ADVISED

PHYSICIAN ADVISING

Care being refused (specify and describe): CT Scan head, Syncope workup.

Risks/complications that can/will result from refusal of the above described advised care (specify and describe)
Include: ~~Loss~~ Death, irreversible brain injury

I certify that, to the best of my belief, the patient understands the risks of refusing care.

SIGNATURE OF PHYSICIAN ADVISING PATIENT/RESPONSIBLE PARTY

SIGNATURE OF TRANSLATOR (IF APPLICABLE)

7/27/00
DATE AND TIME OF ADVICE ☐ AM ☐ PM

I, Patrick Smith acknowledge that on 7/27/00

Dr. Talhar advised me of the above stated risks and/or complication which could or would arise from refusal of the above advised medical care. I understand the risks and/or complication. It is still my desire to refuse the advised medical care stated above.

I do hereby release UCLA Medical Center, its agents, employees and physicians from all liability resulting from an adverse medical condition(s) caused by my refusal of the above advised medical care.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

SIGNATURE OF TRANSLATOR (IF APPLICABLE)

DATE AND TIME ☐ AM ☐ PM

On _____ DATE, this patient/responsible party _____

☐ refused the above stated advised medical care.

☐ left UCLA Medical Center without signing the above release.

☐ left UCLA Medical Center without full medical advice.

M.D./R.N. SIGNATURE

7/27/00
DATE AND TIME ☐ AM ☐ PM

Refer to N.S. Policy No. 202

30904 HA (2/90) S
MR C/010 (A)

DIST: 1) White—Medical Record / 2) Canary—Patient

LEAVING HOSPITAL AGAINST MEDICAL ADV

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☐ FRIEND ☐ POLICE ☐ PARAMEDICS ☐ OTHER

036/195-39-54 3 07/27/00
SMITH, PATRICK
M 66 06/20/1934 SML

VN# 3022

DISCUSSED WITH PMD:

CONSULT PAGED: @:
CONTACTED: DR. @:

☐ TRANSLATOR REQUIRED

☐ RN ASSESSMENT REVIEWED

TELEMETRY STRIP: NSR 76 ̄s ECTOPY 8s

CT/UTZ: Left AMA

RUA:
PREGNANCY:
ABG:

PT:
INR:
PTT:

CK:
MB:
TROPONIN:

Ca:
Mg:
Phos:

AST/ALT:
Alk Phos:
T. Bili:

X-RAYS:

☐ REVIEWED WITH RADIOLOGIST

ECG: NSR 74, nl

OTHER:

☐ PRIOR ECG REVIEWED, ☐ NO SIGNIFICANT CHANGE SINCE: ☐ OTHER:

☐ PRIOR LABS REVIEWED WHICH SHOWED:

☐ PRIOR MED RECORDS REVIEWED WHICH SHOWED:

LACERATIONS

LENGTH	LOCATION		DISTAL ROM	DISTAL SENSORY	DISTAL CIRCULATION	TENDONS	SUTURE TYPE	PREPARATION	ANESTHESIA
CM		☐ SIMPLE ☐ LOCAL ☐ CMPLX ☐ DIGITAL BLOCK	☐ WNL	☐ WNL	☐ WNL	☐ WNL		☐ IRRIGATION	☐ LIDO ___% ☐
CM		☐ SIMPLE ☐ LOCAL ☐ CMPLX ☐ DIGITAL BLOCK	☐ WNL	☐ WNL	☐ WNL	☐ WNL		☐ IRRIGATION	☐ LIDO ___% ☐

☐ I was present with Dr. ____________ during the key portion of the ____________ procedure performed.

X ____________

☐ I was personally present and supervised the entire ____________ procedure performed by Dr. ____________. X ____________

☐ See procedure note
☐ Laceration repair
☐ Endotracheal intubation ☐ RSI
☐ Conscious sedation
☐ LP ☐ Central line
☐ Other ____________

EMERGENCY DEPARTMENT COURSE AND DECISION MAKING - RE-EVALUATIONS AND DIFFERENTIAL DIAGNOSIS

23:48 Wants to leave AMA - doesn't want another W/U. risks explained. AMA signed
[signature]

ATTENDING NOTE: I have examined the patient and agree with the findings and treatment plan of Dr. TAKHAR

Syncopal ̄c fall, hit head - unsure how long out. H/o 3-4 syncopal episodes since head injury in MVA last year - lost Ⓛ vision, p accident - ̄s CT brain, seeing neuro-optomol. ̄c med prob. Atypical CP in past ̄c Ⓒ W/U. Syncopal W/U's ... x @ ...
PE - AAA, NAD, Ⓞx3, GCS 15
CrN's grossly nl
̄c mid c-tender
chest clear
abdomen str...
plan: ̄c PMD to call, as need W/U again → CT head, CBC, chem, EKG

DX: SYNCOPE

DISCHARGE IMPRESSION:
1. Syncope
2.
3.
4.

DISCHARGE PLAN:
1. Pt. left AMA.
2.
3.
4.

CONDITION ON DISCHARGE
☐ GOOD
☒ FAIR
☐ CRITICAL

☐ AMBULATORY
☐ WHEELCHAIR
☐ CRUTCHES

DISPOSITION
☐ HOME ☐ ADMIT ☐ EXPIRED
☐ LEFT WITHOUT BEING SEEN
☒ LEFT AGAINST MEDICAL ADVICE

☐ STABLE FOR TRANSFER TO ____________ VIA ☐ EMT ☐ PARAMEDIC

ACCEPTANCE NO.:

☐ CRITICAL CARE TIME: MINS.

☐ COMPLETE CHART

☐ SIGNED OUT TO: TIME:

SIGNATURE #1 [signature] MD
PRINT NAME Takhar

SIGNATURE #2 MD
PRINT NAME

ATTENDING SIGNATURE [signature] MD
PRINT NAME Gonzales

SEE NOTE ☐
DICTATED ☐